United Nations E/CN.9/2005/NGO/1

Economic and Social Council

Distr.: General
7 March 2005

Original: English

Commission on Population and Development
Thirty-eighth session
4-8 April 2005
Item 3 of the provisional agenda*
Follow-up actions to the recommendations of the International Conference on Population and Development

Statement submitted by the International Women's Health Coalition, a non-governmental organization in consultative status with the Economic and Social Council

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31 of 25 July 1996.

* E/CN.9/2005/1.

05-25983 (E) 230305

Reproductive health and rights: a vital strategy in the fight against HIV/AIDS

1. Ten years ago, at the International Conference on Population and Development (ICPD) in Cairo, 179 Governments agreed that sexual and reproductive health and rights, women's empowerment, and gender equality should be at the centre of the global development agenda. This agreement has been strengthened and reaffirmed at least 10 times since, including by the United Nations Summit on HIV/AIDS in 2001.

2. In 2001, UNAIDS announced that more than half of the people living with HIV/AIDS in sub-Saharan Africa were girls and women. Evidence on increasingly widespread feminization of the HIV/AIDS pandemic is clear and frequently acknowledged. The Cairo agreements charted the course we should take. The international community needs to move forward and much faster to make these agreements reality.

3. The most prominent indicator of our failure to defend sexual and reproductive health and rights is the feminization of the AIDS epidemic. Nearly 50 per cent of the 40 million people living with HIV/AIDS around the world are female, and young women account for 62 per cent of persons aged 15 to 24 living with HIV/AIDS worldwide. In sub-Saharan Africa, 75 per cent of infected young people are female and in many high prevalence countries, adolescent girls are four to six times more likely than boys their age to be living with HIV/AIDS. When it comes to counselling, testing, care and treatment, women frequently have less access than men. Being a married woman is a high risk factor in many countries.

4. Girls and women have even less access than men, and present later, to health services for counselling, testing, care, and ARV treatment. Women experience significantly more stigma than men, as well as twice the level of violence when their HIV/AIDS status becomes known. Women and girls generally bear the brunt of home-based care. All this was predictable.

5. The feminization of the epidemic demonstrates that prevention and care will fail if determinants of the epidemic such as gender inequality and poverty are not addressed — gender influences the spread of the disease, its impact and the failure or success of prevention efforts. Too often messages about HIV/AIDS are narrowly focused on disease control and do not address the many factors that increase girls' and women's risk. Another major shortcoming is the failure to invest in sexual and reproductive health services for all women, including building up their capacity to act in response to HIV/AIDS. In his World AIDS Day message on 1 December 2004, UNAIDS Executive Director Peter Piot said that "prevention methods such as the 'ABC' approach — Abstinence, Be faithful, and use Condoms — are good but not enough to protect women where gender inequality is pervasive. We must ensure that women can choose marriage, decide when and with whom to have sex, and successfully negotiate condom use." Another important issue that has received little attention is the neglect and violation of the rights of women living with HIV/AIDS, particularly their sexual and reproductive rights.

6. There is a growing consensus that a response to the feminization of the epidemic needs to include:

- Reproductive health services, including family planning, safe motherhood, services for the prevention and treatment of STIs and services that treat and prevent gender based violence
- The promotion of girls' primary and secondary education, the guarantee of inheritance and property rights, and the provision of economic opportunities for women.
- The promotion of open discussion on issues of sexuality and gender, increased ability to negotiate safe sex, greater awareness of the need to alter traditional norms about sexual relations
- Better access to treatment and support for the care function that women perform

7. HIV/AIDS leadership and the wider community, recognizing the feminization of the epidemic, increasingly acknowledge the realities of girls' and women's lives that put them at such high risk of infection. The list of these realities is the same as those addressed by the Cairo conference 10 years ago.

8. Before ICPD, the population field focused mainly on fertility control; demographers were its primary experts; and family planning was the main solution. For years, women activists who knew women's realities argued for a wider paradigm. And the 1994 Cairo conference provided an opportunity for debate and a new consensus. While recognizing family planning is essential, the Cairo Programme of Action says it should be delivered through a broader reproductive health and rights approach, together with investment in programmes to achieve gender equality, women's empowerment, human rights, and poverty alleviation. We also acknowledged in Cairo that, going forward, securing and fulfilling adolescents' rights to sexuality education and health services would have to be a high priority.

9. AIDS policies have focused on outreach to core group transmitters; narrow HIV/AIDS messages about the disease, as opposed to sexuality or power or relationships; and condoms as primary means of prevention, with additional attention to such matters as blood safety and protection of health workers. The feminization of the epidemic indicates that these interventions have been woefully inadequate to protect girls and women outside the core groups.

10. Had we invested in gender equality 30 years ago, as the first world conference on women agreed — or in equality, youth empowerment, and sexual and reproductive rights and health, as the Cairo conference agreed 10 years ago — the HIV/AIDS epidemic would not have become feminized, and possibly, not generalized. The international community needs to seriously invest in gender equality, youth empowerment, and sexual and reproductive health and rights going forward.

11. Ten years after the ICPD paradigm shift in population policy, we need another paradigm shift — this time in HIV/AIDS policies — to better prevent infection in girls and women, and also to ensure their equitable access to effective testing, care, and treatment. There is a need for wider and sustained investment in sexual and reproductive health and rights, as defined in Cairo, by the HIV/AIDS community specifically.

12. IWHC suggests two primary shifts in HIV/AIDS policies. The first is to broaden HIV/AIDS strategies to encompass sexual and reproductive health and rights services for the vast majority of girls and women who are not core group transmitters. The second is to promote and support comprehensive sexuality education, not just HIV/AIDS education. Both of these are vital to help today's girls and women protect themselves. They will also be fundamental in preparing communities, individuals, and health and education systems for the crucial processes of testing, developing, and ultimately introducing microbicides and vaccines meant for all populations, not just the core groups. These two investments aim to achieve not only short-term outcomes, but also long-term social changes in gender relations and in respect for human rights, including, centrally, sexual and reproductive rights.

13. Achieving this crucial HIV/AIDS policy paradigm shift, requires work with policy makers, and the epidemiologists and economists who advise them, to think anew about the underlying dynamics driving the HIV/AIDS pandemic. It will require engaging our currently separate communities in partnership: the HIV/AIDS community, women's health advocates, human rights activists, and the reproductive health/population field. It will also require leadership, time, and resources. The payoff will be huge — saving millions of lives.

United Nations E/CN.9/2005/NGO/2

Economic and Social Council

Distr.: General
7 March 2005

Original: English

Commission on Population and Development
Thirty-eighth session
4-8 April 2005
Item 3 of the provisional agenda*
Follow-up actions to the recommendations of the International Conference on Population and Development

Statement submitted by World Population Foundation, a non-governmental organization in consultative status with the Economic and Social Council

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31 of 25 July 1996.

* E/CN.9/2005/1.

05-25971 (E) 220305

The Feminisation of Hiv/Aids

WOMEN ARE INCREASINGLY AFFECTED

1. At the 38th session of the Commission on Population and Development, we can conclude -besides the fact that the total number of people living with HIV has risen to reach its highest level ever (an estimated 40 million)-, the Aids epidemic is affecting women and girls in increasing numbers. Globally, just under half of all people living with HIV are female, whereas this figure was still at 12% in 1995. Women and girls make up almost 57% of all people infected with HIV in sub-Saharan Africa, where a striking 76% of young people (aged 15–24 years) living with HIV are female. In most other regions, women and girls represent an increasing proportion of people living with HIV, compared with five years ago.

THE FEMINISATION OF HIV/AIDS: more than a women's issue

2. There are several explanations for the feminisation of HIV/Aids, yet, the most important and effective areas of intervention are socio-economic and those in health care structures.

Low social status and lack of power

3. Women have, due to their physical vulnerability, an increased risk for infection. Besides this biological aspect, another reason is that women and girls do not have adequate information about Aids. A recent UNICEF survey found that up to 50% of young women in high-prevalence countries did not know the basic facts about AIDS.

4. Yet the vulnerability of women and girls to HIV infection stems not simply from nature or ignorance, but from a social aspect: their pervasive lack of power and low social status. Most women around the world become HIV-infected through their partner's high-risk behaviour, over which they have little if any control.

5. In many societies, men have the power to determine whether sex is safe or unsafe, forced or consensual, pleasurable or painful. Women, on the other hand, are expected to be ignorant about sex and passive in sexual interactions. For unmarried girls traditional norms of virginity are prevalent, meaning they cannot carry a condom because of the connotation "they are easy to get". For many men and boys, expectations are the complete opposite: they are supposed to be sexually active.

Isolation of HIV/Aids programmes

6. Due to the urgency of HIV/Aids and the public pressure to do a better job to fight the epidemic and make treatment available on a larger scale, larger HIV/Aids-specific programmes have started. These have often been set up isolated from the primary health care structure and sexual and reproductive health care programmes in particular. This could lead to pulling away (human) resources from the primary health care structure –including sexual and reproductive health-, and will eventually lead to the erosion of the overall health-care structure.

7. Further, given the fact that almost 80% of HIV cases are transmitted sexually and an additional 10% are transmitted from mothers to children during labour or delivery or through breastfeeding, linking HIV and reproductive health services is crucial in prevention. Obviously, this counts in particular for women as they are most vulnerable. At the same time, sexual and reproductive health services are not only important when aiming at prevention of HIV; they are also important for reducing unwanted pregnancy, unsafe abortion, maternal mortality and STI's. Further, they can improve women's social status and opportunities.

8. The practical implications of *not* linking both areas of prevention are problematic. One example is that a woman has to go to one clinic for a pregnancy test and to another for an HIV-test, which is not only unpractical and costly but it might also enforce the stigma related to HIV/Aids. This clearly has a relation with the feminisation of the Aids pandemic: HIV/Aids programmes haven't succeeded in or prioritised reaching out to girls and women.

9. People living with HIV (including women) have their sexual and reproductive health needs as well, whether they are treated for or not. They need counselling on safe sex, counselling related to contraception and pregnancy and specific services in this respect.

Successful integration of sexual and reproductive health services and HIV/Aids initiatives can result in reaching out to more groups of women who have access to a broader range of services and education via one entry-point and, at the same time, becoming more responsive to their needs.

RECOMMENDATIONS

10. Gender considerations are crucial in the fight against HIV/Aids, yet, they are hardly taken into account: empowerment of women is often seen as an issue of the women's movement, put aside as something marginal. However, the plight of women and children in the face of AIDS underlines the need for realistic

strategies that address the interplay between inequality -particularly gender inequality -, sexual and reproductive rights and HIV.

11. The realisation of sexual and reproductive rights counteracts the feminisation of HIV/Aids and the epidemic in general and contributes to the empowerment of all women and to a more equal and prosperous world.

12. In order to improve the sexual and reproductive health of all women, regardless of age, religion, culture, ethnicity or sexual orientation, the following concrete actions should be taken:

Concrete Actions Points should be:

- **Improve women's access to health care systems by the integration of HIV/Aids programmes and sexual and reproductive health services;**
- **Improve women's access to information on sexual and reproductive health, the prevention of unwanted pregnancy, HIV/Aids, STIs and sexual violence; and to services including safe abortion, counselling and treatment;**
- **Involve women living with HIV in the design of programmes to improve the services for this group of women;**
- **Invest more in the development and implementation of preventive measures that are friendly to women, such as microbicides;**
- **Link these action points to other criteria that empower women, such as the right to education and the right to health care for women; and the involvement of men.**